



# Authorization to Release Substance Abuse Treatment Information

This form, when completed and signed by you or a personal representative having legal authority to execute this authorization on your behalf, authorizes Directions Counseling Group to release protected health information (PHI) from your clinical record to the person/agency you designate.

## Personal Information

Today's Date: \_\_\_\_\_ Person Requesting Release: \_\_\_\_\_

Relationship:  parent  guardian  POA,  other: \_\_\_\_\_

Client Name: \_\_\_\_\_ Client's DOB (mm/dd/yy): \_\_\_\_\_

## Authorization

I authorize (the clinician) \_\_\_\_\_ of Directions Counseling Group to:  
 release client PHI to: \_\_\_\_\_  obtain client PHI from: \_\_\_\_\_  exchange client PHI with: \_\_\_\_\_

Individual: \_\_\_\_\_ Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Please provide the following information (check one or more of the following):

- Summary of Treatment/Progress
- Intake Assessment
- Diagnosis
- Treatment Plan
- Psychological Testing Results
- Dates of Service
- Fees for Service
- Other: \_\_\_\_\_

The general purpose of this request is for:

- Evaluation/Assessment
- Continuity of care/Medical Care
- Transfer to a new clinician
- Disability
- Adoption Planning
- Other: \_\_\_\_\_

## Method of transfer (applicable fees may apply, see other side for details)

**Internal Transfer** – no fee – move to “Revocation” section

**External Transfer:**

Copy PHI to (choose one):  flash drive  CD  paper

Distributed via (choose one):

- mailed to above address
- picked up by: \_\_\_\_\_ I am aware that this person will be required to show a state issued ID in order to pick up this documentation.
- fax PHI - Fax number: \_\_\_\_\_
- email PHI - Email address: \_\_\_\_\_

I am willing to have my PHI shared via unsecured email or fax and I have been made aware of the risks that are involved by using this form of unsecured communication means. Initials: \_\_\_\_\_



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## Fees

Phone calls, letters, summaries, reports and other non-session related items provided by a clinician are billed at \$30.00/10 minute increments.

Hard copies: A client, a personal representative of a client or a third party requesting records will be charged according to what is allowable under Ohio Law as determined in Ohio Revised Code 3701.741.

Flash Drive/Disk: A client, a personal representative of a client or a third party requesting records will be charged \$20 covering the cost of the device and the processing involved with transferring the PHI onto the device. *DCG will provide the device and will not accept a device from an outside source.*

Rush Orders: If a file is at our external storage facility and requires 24 turn around, a fee of \$85 will be assessed and must be paid prior to the transfer being made.

## Revocation

I understand that I have a right to revoke this authorization at any time by sending written notification to Directions Counseling Group. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. This consent will automatically expire one (1) year after the date of my signature as it appears below, unless indicated otherwise here: \_\_\_\_\_

## Conditions

I understand that in some circumstances, by not signing this agreement, my therapist may condition providing me mental health services.

## Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

## Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.

I, the undersigned, authorize this release of information:

\_\_\_\_\_  
Print Client Name Date

\_\_\_\_\_  
Signature of Client (or authorized Parent, Guardian or Personal Representative)

\_\_\_\_\_  
Signature of Witness Date

Check here if patient/client refuses to sign